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ABSTRACT

There is relatively little theory on how psychotherapy clients self-heal since most theories of therapy stress the magic of the therapist's interventions. Of the theories that exist, this paper briefly discusses Carl Rogers' theory of self-actualization; and the dialectical theories of Greenberg and his colleagues, Jenkins, and Rychlak. Gendlin's theory is discussed in detail. It examines how we create new meaning, and in terms of psychotherapy, specifically how personality change can take place. Gendlin holds that as we encounter each new situation, there is an implicit potential for new development or "the carrying forward" of old concepts, rules, words, or ways of being. The theory proposes that the process of self-healing is a creative one of tuning into the implicit experienced complexity of a problem, from which implications or new steps arise. This paper discusses Gendlin's theory in relation to personality change and implications for theory. The concept of self healing is examined and two counseling cases that utilize self-healing in different ways are discussed. The theoretical integration of self-healing is also discussed. (Contains 45 references.) (MKA)

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An Implicational View of Self–Healing and Personality Change Based On Gendlin's Theory of Experiencing

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Bohart and Tallman (1999) have argued that the underlying process in psychotherapy is one of client self–healing. Therapy is "professionally coached self–change" (Prochaska, Norcross and Di Clemente, 1994). This is not a popular view among psychotherapists who assume that therapeutic change is primarily a product of their interventions. However, Bohart and Tallman (1999) have argued that interventions are really tools which clients use to self-heal. Furthermore, most clients are capable of fixing themselves with a wide range of tools from many different therapeutic "toolboxes."

Self healing is the core of change in all approaches. However in cognitive-behavior therapy, psychoanalysis, and experiential approaches (e.g., Greenberg, et al., 1993; Mahrer, 1996), it is difficult to distinguish self–healing from therapist procedures because therapist procedures highly structure what happens in therapy. There are three approaches which particularly emphasize the capacity of clients to self–heal: client–centered therapy, eye movement desensitization and reprocessing (EMDR), and focusing–oriented therapy. In these three approaches clients spontaneously generate a self healing process which is only minimally guided by the therapist. However, Mahrer's experiential therapy, when done as a self-help procedure, also demonstrates many of the same self-healing processes as do these three approaches.

There is relatively little theory on how clients self-heal since most theories of therapy stress the magic of the therapist's interventions. Of the ones that do exist, I shall mention Carl Rogers' theory of self-actualization; and the dialectical theories of Greenberg and his colleagues (Greenberg & Paivio, 1997; Watson & Greenberg, 1996), and of Jenkins (1996) and Rychlak (1994). Then I shall consider in some detail Gendlin's (1962, 1964, 1990, 1997; Levin, 1997) theory. In all theories humans are seen as having an intrinsic possibility for generating positive, proactive, more integrative ways of dealing with life on their own, and the question becomes: How does this occur?

Rogers' Self-Actualization Theory Rogers' (1961) theory of self-actualization stresses acceptance of inner experience. Because of conditions of worth in childhood individuals come to view their inner experience distrustfully. They tend to hold their beliefs or constructs rigidly, and to trust them more than their own inner feelings. Their experience, however, is a source of "organismic wisdom." As they slowly and painfully learn to listen to it in therapy, they find themselves able to shift more and more towards developing their own answers. This appears to be one component in the self-healing process.

Dialectical Theory In dialectical theory it is assumed that the client, or the therapy process, generates the opposite of the client's previous point of view or response. This then leads to a synthesis and change. In Greenberg and colleagues (e.g. Greenberg & Paivio, 1997) theory the therapy process accesses dysfunctional emotional states. This allows their contrary--functional emotional states to emerge. This is similar to what happens in Mahrer's (1996) experiential therapy, where accessing bad feelings leads to the emergence of what Mahrer calls "deep experiencing potential," which is a more positive potential. For instance, for Greenberg and Paivio, a person may initially be experiencing intense shame over having been sexually abused. Through accessing and experiencing the shame, its opposite, a healthy anger may emerge. Typically the person neither reverts to a shame position, nor stays stuck in a focused–on–the–other anger condition. Instead, the person synthesizes the negative self–focus in the shame with the implicit positive self–focus in the anger condition to emerge with a stance of healthy self–affirmation ("I'm okay no matter what he or she did"). The procedures used by Greenberg and

his colleagues all include a dialectical "back and forth," such as in the chair work procedures borrowed from Gestalt therapy.

For Rychlak, humans are capable of thinking of the opposite of any given point of view. To understand point A means that one also understands its opposite, or not–A. Thus, to understand shame, humiliation and defeat means the person also understands pride and healthy self-affirmation. The experience of one implicitly contains the other. To think dialectically means that the person adopts a "preaffirmative" position (Jenkins, 1996), which is to stand back and not adopt or accept any one point of view, and then to consider alternatives. In therapy, a person who is feeling "I'm bad," instead of thinking from within that, stands back and begins to consider alternative points of view. This allows the implicational opposite of the dysfunctional way of thinking to emerge.

Both of these theories assume that humans are capable of creating their own change process under the right circumstances. Dialectics has its own "inner logic." The therapist's role is to facilitate adoption of an exploratory, preaffirmative stance and acceptance of position A; so that position not–A can be generated, and the individual can then engage in a dialectic between these two positions until a more productive higher–order synthesis emerges.

A question arises as to why, if people are capable of going through the process, they do not always do it until they see a therapist. Tallman (personal communication, August, 1999) has proposed in everyday life people are not allowed by others or do not allow themselves to consider an extreme of a position. If they say "I'm no good" people immediately try to talk them out of it. If they say "I'm suicidal," people get scared and try to talk them out of it. They may even be afraid of these thoughts themselves and so try to avoid them, even if the very action of trying to "not-think" them makes them stronger and more persistent (Wegner & Bargh, 1998). Tallman suggests that as part of the dialectic people may need to be allowed to consider the extreme, to fully examine it and even temporarily "be" it . Sometimes it is through facing the possibility of death or loss that a renewed desire to live and move on is generated. Individuals, given the chance to fully consider a negative possibility such as "life is not worth living," or "I can't live without her," or "if I have a terminal disease there is no point in going on," then may realize that it is too extreme, and it generates its opposite.

In everyday life people are too afraid of people killing themselves, or of getting more negative, to allow another person to really experience, express, and "dwell with" hopelessness or negative self-doubts. People immediately try to move the person to a more "balanced" position, but may, in so doing, interrupt a step in a positive healing process, which is the full expression and through that expression, confrontation of the hopelessness and despair. Individuals themselves may be too afraid to "indulge" in the extreme, fearing they will get stuck in it, especially if they do not have a supportive other person to do it with.There is some sense in this. People can get stuck in such negative thoughts and feelings and do not always automatically bounce back to a "life-forward" alternative. Nonetheless, too much unwillingness to confront the negative may stymie a component of a natural self-healing process.

The idea that allowance and acceptance of negative experience is a component of healing is an insight which many therapists have had. Humanists, such as Gestalt therapists and others, have long had the insight that there is a kind of paradoxical quality to change. One must fully accept where one is, in order to change (recently, from a cognitive-behavioral point of view, Linehan, 1993, has had the same insight). In substance abuse work it is sometimes believed that one must

"hit bottom" before one can discover that one's desire to live is stronger than one's desire to use substances. It is also a key part of strategic and solution–focused approaches. Paradox and reframing allow or encourage people to "have" one pole of their experience, which they have been fighting against. Once they adopt that pole, they then can let it go and move on to the opposite pole.

An interesting example of the power of acceptance of the negative is given by Arthur Kleinman (1988). When Kleinman was a medical student one of the first patients he worked with was a seven year old girl who had been badly burned. Everyday she had to undergo a procedure where she was put in a whirlpool and the burned flesh plucked away from raw, open wounds with tweezers. This experience was exceedingly painful, and the little girl fought against it every day. Kleinman's assignment was to hold her hand and try to reassure her and calm her as the procedure was carried out. At first Kleinman tried to distract her by talking about other things. However he only was able to help her when he finally asked her what it was like for her to be so horribly burned and to have to undergo this experience. At that point she suddenly calmed down, stopped fighting against the procedure, and began to relate her experience to him. From then on each day she talked about her experience as she was undergoing it with him, and this seemed to significantly help her ability to tolerate the procedure.

Acceptance of negative experience means something akin to allowing it so that one can face up to it, confront it, and learn from it. It does not mean "wallowing" in it (Gendlin, 1964). Nor does it mean that accepting and expression will magically "discharge" negative emotion from the body in a cathartic kind of way (see Kennedy-Moore & Watson, 1999, for research on the nonviability of the catharsis concept). Further, there is no guarantee that acceptance magically will always lead to one's coming out the other side. It may take acceptance in a supportive atmosphere, with a therapist who can be a guide to help one through it if one happens to get stuck in it (see, for instance, the use of the cognitive interweave with clients in EMDR who get stuck in negative emotion, Shapiro, 1995).

Nonetheless a dialectical position makes sense. Considering both poles of a concept, an experience, or a problem, may often be necessary for one to transcend the either/or involved and move on to a more adaptive integrative position. However, I think that a dialectical position is insufficient to account for the complex nature of change in therapy. I believe Gendlin's implicational theory is a more encompassing one that can handle dialectics and other kinds of changes. Gendlin (1997) himself sees dialectics as one particular kind implicational process.

Gendlin's Theory Gendlin's theory can be expressed in the title of his first book Experiencing and the creation of meaning (Gendlin, 1962). Gendlin has been interested in how we create new meaning, and in terms of psychotherapy, specifically how personality change can take place (Gendlin, 1964). While Gendlin is most well–known to psychologists as a theorist and researcher on psychotherapy, Gendlin started out as a philosopher and has continued to develop an important philosophical position (Levin, 1997) on the nature of language, concepts, and meaning, and their relation to bodily lived experience.

Gendlin's ideas are in accord with other theorists who hold that the nature of human knowing and experience is not fundamentally conceptual. Many cognitive theorists believe that if I see a barking dog and experience fear, it is because I hold a belief that the dog is dangerous. Cognition, in the form of concepts and schemas, become the underlying structure of how we know the world. In therapy, when the client identifies and articulates a dysfunctional belief, he or

she is presumed to be reporting what is already there. Thus, if I tell the therapist "I believe I'm no good," it is assumed that I am merely putting into words and reporting this underlying, fully formed belief. Further, I "see" the world through this fixed concept, which determines how I experience the world.

In contrast, Wittgenstein (1974), Gendlin (1997), Lakoff (1987), Ward et al. (1995), Bellezia (1984), and others have pointed out that concepts do not have fixed meaning. Instead, their meanings shift and change as a function of the situation the person is using the concept in. Concepts are continuously being invented anew (Gendlin, 1997; Ward et al., 1995, Wittgenstein, 1974). Gendlin (1997) notes "Wittgenstein ....showed that a word says (means) what it does in a situation. He could give a series of twenty or more quite precise, yet different meanings for the same word. The different uses have 'no feature in common,' he showed. No concept determines what a word means". (p. 7). More deeply, many theorists now assume that experience is not primarily conceptual. Lakoff (1987) and Johnson (1987) have both argued that experience is bodily, metaphorical, and preconceptual. Concepts come from experience, but are not themselves the underpinnings of experience. Barsalou and Prinz (1997) have argued that the mind is fundamentally perceptual and not conceptual. Finally, neural network theorists (e.g., Caspar, 1998) have questioned the idea that the mind is made up of fixed, discriminable propositional schemas, and have provided alternative, nonpropositional models.

Gendlin's view is that experience is more finely ordered and intricate than any of the words and concepts we use to describe it. Gendlin (1997) says, "Language brings patterns and distinctions, but what it says exceeds them" (p. 3) and "We can recognize from the start that experience is not given in already–formed units which cognition could simply observe, represent, or approximate. Experience is "non–numerical and multischematic," (6). He also says, "A situation [and the experience of the situation] is so finely ordered that almost anything we say about it is too simple" (p. 32). While agreeing with Lakoff, Johnson and others that concepts come from experience, Gendlin argues a) that concepts do not merely report on already formed experience, and b) it is not really accurate to say that experience is "preconceptual." Although it is preconceptual in the sense that there is more in experience than can be put in words, concepts are themselves a part of that experienced complexity.

Gendlin believes that when one "puts experience into words," one does not merely report on something already formed. Instead, the very act of putting it into words changes and carries experience forward. "Experiences....do not consist of fully formed givens that our articulations could just represent. Speaking from situations does not make copies or approximations. Speaking is like living and acting." (Gendlin, 1997, P. 31). In addition, experience is not preconceptual, because it can understand concepts. We can know in our bodies when the concepts we have chosen to represent an experience do not fit. We say to ourselves: "That's not quite right. That's not it....it's more like...."

Words and concepts therefore never fully capture experience. There is always a "more" that lies implicit beyond the words and concepts we have chosen to represent experience. This is easily demonstrated. You can think of a time when you tried to convey a point to someone. You recognized that you had not conveyed it. So you try rephrasing it. But what is the "it" you are trying to rephrase? And how did you know that the words and concepts you chose to express "it" did not fit? Gendlin says that the it is our felt sense of what we are trying to say. It is our implicit "preverbal" (in the sense of "lying before the words we choose to use to express it") bodily felt

sense of what we are trying to convey. We can rephrase "it," or try to put "it" "in other words" because we have such an implicit preverbal sense. However it is also interesting to note that the point is never exactly the same when expressed in different words or concepts. It changes. Thus, when you "rephrase" what you have tried to say "in new words," you find the point to be "clearer," or "sharper." Whenever you put the meaning of what you are trying to get at into new words or concepts, you carry it forward. It changes.

Therefore, a) words and concepts do not have fixed meaning, b) their meanings change as a function of the contexts they are used, c) words and concepts do not "represent" experience; rather they express it and carry it forward, and d) there is always implicitly more meaning and finely ordered complexity "behind" or "underlying" the words and concepts we have used than we have articulated. Once again, this last point is demonstrated by a direct appeal to our experience. Most of us have had the experience of struggling to put something into words. We grasp for the right words, almost as if we were flailing about. And when we find the right words there is a sense of rightness and relief.

Gendlin holds that the experienced complexity that underlies words and concepts implicitly contains the situations we live in. Experience is concrete and situational. Past learnings and any words, concepts, philosophies or rules that have been carried forward into the current situation "cross" with the current situation to both influence experience of the situation, and be influenced, so that their meanings subtly change and be carried forward. We know more than we can say. This last point is not a shock to modern psychology, many of whom now are willing to believe in "tacit" knowledge (e.g., Mahoney, 1991). However, Gendlin has come up with a unique theory of what tacit knowledge is and how it operates. Tacit knowledge is bodily based experiential knowledge, and includes implicitly our situations. "...every person speaks from somewhere, situated in midst of life and situations" (Gendlin, 1997, p. 3). "Heidegger said that your mood understands more about what you are doing, and why, than your cognition can reach. Situatedness is how you are (living in, enacting, being, feeling, knowing, finding, making...) your situations" (Gendlin, 1997, p. 32). In one key way we are our situations. Using the analogy of a plant, Gendlin points out that the plant is the nutrients it gets from the soil, the sunlight, and the water. There is a kind of organic relatedness or embeddedness between the plant and its surroundings. The "nature" of the plant reflects its surroundings, and vice versa. To put this in other language, we could say that when a person enters a situation, he or she is not a fixed, completed self–contained monad which merely moves through the situation. Rather, he or she is implicit interactivity, a living process designed to be interactive, and to "complete itself" through interaction. Using again Gendlin's idea of crossing, that meanings take on their concrete situational meaning only by "crossing" with the situation, our concepts, traits, beliefs, ways of being, and so, "cross" with each concrete situation we are in to create new and unique meanings. We are never quite "the same" from situation to situation, any more than a word or concept carries invariant meaning from one situation to the next.

Therefore, as we encounter each new situation, there is an implicit potential for new development, or the "carrying forward" of old concepts, rules, words, or ways of being. In each situation we are "making ourselves anew" in the sense that we are using/being our old learnings as crossed with new situations. Gendlin (1997) says, "A living body is a self–organizing process" (27, italics mine). "Anything experienced is further differentiable, and in various ways (Gendlin, 1997, p. 7). Not only does experience...not come in cognitive units; we will also recognize that it

is always open for further living and action. And not just open; it often demands further steps; then we are not at liberty to invent them as we please, and yet they are not already determined." (Gendlin, 1997, p. 7). In other words; there is always an implicit openness to experiencing because of our ability to experience beyond whatever words, concepts, or rules we are using in a given situation. There is always room for a new step. Further, and most important to us as therapists there are situations where new steps are demanded. These are just the situations where our old rules, concepts, ways of dealing, are not working, and we must go further. And implicitly we know what a next productive step is or will look like. "The body of a plant or an animal projects...its own next step" (Gendlin, 1997, p. 27). If we try to intellectually manufacture a step, and it does not fit, we can feel our bodies resisting. We know that is not right, just as we know when we have chosen a word or a concept to express an idea and that is not quite right. Similarly, we can know what an idea (say, given to us by a well–meaning therapist) does not fit, even if we think it "should" fit. Our bodies say "no." And when we find the right step there is a sense of relief, or release (Gendlin calls it a "felt give"). Often, when that step is identified, taken, and acknowledged, then we are able to use the good advice someone else has given us, but not until that step is taken.

To demonstrate this last point I mention the often reported phenomenon of people in therapy saying "I knew that all along! Why did it take me so long to figure it out!" We have the sense of knowing what is needed to carry the situation forward productively, but we are unable to "put it into words" or identify what it is.

Gendlin's view of how people change gives an alternative view of how people self–heal in or outside of psychotherapy. For Gendlin, the process is a creative one of tuning into the implicit experienced complexity of the problem, from which new implications or new steps arise. "Anything experienced is further differentiable, and in various ways" (Gendlin, 1997, p. 7). Yet, while there may be several different ways of carrying forward experience into new solutions, not just any steps will do. As Gendlin notes, "we are not at liberty to invent them as we please, and yet they are not already determined."(Gendlin, 1997, p. 7). It is very similar to a creative solution to a problem. Only certain new solutions will work and carry the situation forward. Psychotherapy is just this process of helping people "think forward," from where they are to new ways of being and behaving. However, "thinking" here means more than strictly logical thinking. Gendlin (1997) also notes that too often thinking is merely going from concept to concept in a logical "if...then" fashion, and that does not work when one needs to think afresh. One needs to be able to tune into the experienced implicit complexity. Thinking then means thinking that includes both words and concepts and whole–bodied experience, letting them cross, uncross, and recross so that new meanings emerge, either in the form of new words and concepts, or in the form of old words and concepts now understood in new ways.

When this happens, the new words and concepts, or the new understandings of old words and concepts, "carries forward" experiencing, so that one is now different. This is not merely a "cognitive change;" this is a whole–bodied felt shift or change. One now experiences the world differently. Once again, what Gendlin is saying can be directly tested against our experience. Most of us are aware of "intellectual insights" which "must seem right," yet do not change anything--in contrast to those "aha" experiences, where we "get it in the gut." It is precisely this difference between intellectual understanding and bodily felt experienced understanding which has puzzled psychotherapists for the last 100 years, ever since Freud (Todd & Bohart, 1998).

Therapy research has demonstrated that certain kinds of thinking and talking are not productive, while others are (Mathieu–Coughlan, & Klein, 1984; Rice, Kerr, 1986). Those that are not productive are when the client is merely reporting facts, incidents or experiences, when the client is abstractly and philosophically thinking about what must be right or wrong about the self, and when implications are strictly logical and intellectual. Gendlin (1964) has noted the uselessness of abstract theorizing about one's problems. When clients are thinking productively in therapy they are not merely reporting their experience. Nor are they merely logically analyzing. Instead, they are struggling to articulate and understand through a process of trying to put their experience into words. Their talk is characterized by a focused vocal quality, which consists of stops and starts in speaking (as if someone is struggling to articulate and think; Rice & Kerr, 1986). Additionally they are trying to express their experience rather than merely report on it (Mathieu-Couglan & Klein, 1984) and there is an experiential quality to what they are saying; they are merely reporting "dry" facts—they are experiencing (Mathieu-Couglan & Klein, 1984, high levels on the Experiencing Scale; and Rice and Kerr, 1986, emotional vocal quality).

From Gendlin's point of view, there is an implicit order of steps (Gendlin, 1990) which can carry forward experience in new and more productive ways. Individuals who are able to "focus" and tune into their experience in this particular way, may be able to initiate this process on their own. The process of unfolding the implicit complexity, however, is more than dialectical. It is implicational. That is, any next step is implied by the previous one, but it is not necessarily a dialectical opposite. Sometimes the next step is a dialectal opposite. But that is just one kind of implication. Sometimes it is an elaboration, a differentiating, an associative shift to another topic, or a creative leap forward with a new word or concept. As we shall we when we examine examples later, some steps are implicational in the sense that A implies B, and others are dialectical. Therefore, while I value the insights of a dialectical approach, I will subsume it under a broader implicational model. With this in mind I turn to personality change.

Gendlin, Implication, and Personality Change

What is personality change? The client centered perspective is committed to the view of the person as ever–changing. People are continually self–actualizing --they never reach a state where they are self–actualized. Yet both psychodynamic and trait approaches (McCrae & Costa, 1990) assert that personality is fixed and that change is difficult. Even recent cognitive approaches have talked about underlying core schemas that underlie experience and remain relatively unchanged (Mahoney, 1991).

Psychoanalytic models assume that the "foundations" of personality are set down in early childhood. These constrain, shape, and determine later personality formation. Development, from such a perspective, can be represented pictorially as a pyramid, with the most important foundational things happening in early childhood, at the bottom of the pyramid. Age becomes progressively less and less important in shaping personality.

Yet client–centered theory is committed to a view of the person as ever–changing. How can this be reconciled with a view of personality fixity? Fixity views include unspoken mechanistic metaphors that portray personality in terms of structures such as traits, egos, and core schemas. While the metaphors are never entirely spelled out, all of them are described as if they were structures "in" the person which then determine behavior. Core schemas operate like programs

to drive behavior. Traits are fixed action dispositions that shape and constrain behavior.

If one conceives of personality change in this form, then change must indeed be changing traits, core schemas, or ego structures. Change becomes a difficult and messy business. Significant change becomes a matter of "second order change" (Watzlawick, Weakland, & Fisch, 1974). Second order change is essentially a paradigm shift (Kuhn, 1970) where the fundamental dimensions of understanding, the premises, are themselves questioned, and a whole new way of "seeing" emerges. Presumably one changes a "dependent" personality into an "independent" personality, an "antisocial" personality into a "prosocial" personality, an anxious, insecure person into a calm, confident person, a shy person into an assertive outgoing person, and so on.

However there is another way of looking at change. This kind of change does not emphasize paradigm revolution so much as paradigm evolution. This view of change does not even believe that changing traits, core schemas, and the like is necessary in order that significant change take place in therapy. Rather, traits and core schemas can stay "the same," and important change can occur none the less.

In this kind of change pre–existing frameworks, the overarching edifices of experience may stay " the same," although, as we have seen, from Gendlin's point of view they really are not "the same" meaning "identical," because they continually cross with situations and become altered. Over time, within these frameworks significant evolution may take place.

Consider examples from intellectual work and from societal evolution. For instance, Freud's work continually evolved over the course of his life span. Nevertheless it was within his "Freudian" paradigm. Similarly, law and government have both evolved and changed in the United States since the U.S. Constitution was ratified in the late 1700's. The "core schema," or "character structure" of the United States government has thus remained "the same" for 200 years, yet significant change has also taken place.

Thus, while basic abstract guiding frameworks may remain "the same, " significant change can occur in the form of "fleshing out" and evolving of these frameworks. In a like manner personality can therefore change in personally significant ways even if one's "traits" or "core beliefs" remain the same. Many traits can be manifested in either positive or negative ways. Aggression can come out as positive, proactive assertion, or as destructiveness. Dependency can come out as clinginess or as mature caring and bonding with a significant other (e.g., Caspi, Bem, & Elder, 1989). Therapy may not change the individual's propensity to be aggressive or to be dependent, but it may alter how this propensity is manifested, "fleshed out," or operationalized – from negative to positive.

This leads to a fundamentally different view of therapy. The goal of therapy is not so much to change personality as it is to evolve personality. Aggression can be accepted, listened to, and differentiated, so that it can evolve into a productive aspect of the personality instead of a destructive aspect. Even self–criticism can be productively evolved so that it is not a dysfunctional part of personality (Bohart, Greenberg, Driscoll, & Wessler, 1991).

From a field, ecological, contextual, or narrative view of personal knowing, the meaning of any given trait, idea, or construct, is not a fixed, invariant property of itself alone anyway. Rather, it exists in a context of other relationships. The meaning of a trait partially depends on how it is organized, integrated into, and "crosses" with other traits, goals, values, and the like. As we grow our organizations of goals, values, traits and the like, expand, becoming more differentiated and integrated. In this respect personal evolution resembles the process of

evolution of life from amoebas into more differentiated life forms. Thus development from this perspective could be represented as an inverted pyramid. Earlier elements indeed form the building blocks of later experience, but are incorporated into progressively more and more expansive, complex, organized, and overarching organizations of experience. The meaning of a trait or core schema is colored by its place in a network of relationships, which shifts over time.

However there is something more fundamental about human knowing. The key idea is the process nature of knowledge. Knowledge is not fixed. When we talk about traits and core schemas as if they are somehow monadic, encapsulated little units, we miss the organic nature of knowledge. Human knowing is recursive. What this means is that later learning, knowing, and experience, feeds back to re–configure earlier learnings. Thus, even if core schemas persist from early childhood, their meaning may shift, perhaps only in subtle ways. Again, as we continually experience our "core schemas" in new situations, as they "cross" with new experience, and as we reflect on them., their meaning is continuously evolving.

An example is again the United State Constitution. There are continuing battles over its "original meaning." However even conservative judges have admitted that the actual original meaning is undecidable. It is always being seen through the further knowledge of centuries. Clearly, while the "core schemas" of the governmental structure of the United States have remained "unchanged" (in some sense) over 200 years, at the same time they have changed in how they are interpreted, understood, and used.

This happens because knowing, and knowledge, have a fundamentally implicational nature, as I have previously argued. Any act of knowing, any formulation of knowledge, any organized schema, has built into it the potential for an implicit "next." As I have noted, the recognition that much of knowing is tacit and implicit is now widespread (Mahoney, 1991). But in most accounts of tacit knowing its tacitness is attributed to its automaticity and its nonconscious nature. Certain knowings are learned so automatically that they "run" at a nonconscious level.

Many modern cognitivists portray the tacit level of knowing as a routinized and mechanized level of procedural scripts and schemas. It is more simplistic than conscious, conceptual knowing. Those who hold this view also hold that all procedural knowledge originally started as conscious conceptual knowledge, giving total primacy to cognition as conceived of as concepts, rules, schemas, beliefs, and processes of analysis. Experience consists essentially of little concepts, implicit to be sure, but fundamentally conceptual. A computer analogy is implied in which fixed conceptual algorhythms, precisely defined, underlie and create experience.

None of this handles the fact that what is tacit about knowing and knowledge is that it always contains implications for a next step (Gendlin, 1990). The tacitness of knowledge is not merely due to a stamped–in automatic nature. To the contrary, tacit knowing is fundamentally rich in its implications for new knowing. There is therefore a creative aspect to tacit knowing which is not captured in concepts like "controlled" versus "automatic" processing.

This was brought home to me most forcefully by my experience as an undergraduate whose major was mathematics. In mathematics theoreticians set up a set of postulates, and from that set, derive a number of theorems. Often, the theorems are already known, and the formalization of the system is merely to organize the derivations into a logical and consistent form. The interesting thing, however, is that from that same set of postulates new, unexpected theorems can be derived. One of the most famous cases of this was Godel's demonstration from attempts to formalize proofs in number theory that a system with sufficient complexity could not be shown

to be both complete and consistent at the same time (Hofstader, 1979).

Thus, even in the most logical and formal of disciplines, the encoding of ideas in some kind of language seems to "allow" that there be more implicit in them than is spelled out. Thus knowledge by its very nature is not fixed, but contains a potential for "more." As Gendlin (1997) has noted, even logical thinking itself is based on implicit complexity. "Logic....always involves implicit assumptions that remain unexamined" (p. 10). In other words, even in a mathematical theorem or proof there is an implicit dimension which makes the proof understandable, and which provides the basis for understanding the proof. It is from this implicit complexity that new theorems can be derived, or it is because of this implicit complexity that new theorems can be derived.

Thus knowing is always inherently incomplete and unfinished because knowing itself always seems to imply a "more." Any act of knowing of sufficient complexity, a la Godel (1962), beyond simple name recognition and memorization of multiplication tables, will have within it a richness of potential implication for further evolution.

Gendlin (1968) notes that the function of therapeutic responses is to "point" towards implicit experiencing. The function of words is to explore experience, rather than to somehow "copy" it into words. If we think of verbal formulations as attempts to "copy" reality, then it is unclear how a formulation could have an implicit next built into it. However, if we think of words, concepts and ideas as "tools" to be used to explore reality, then it is easier to understand how an idea has built into the potential for discovery.

This leads to a view of knowing as a kind of "unfolding" (Gilligan, Brown, & Rogers, 1990) or discovering of new potential in what was already known. Early formulations of self and world are crude, superficial, vague, and abstract. Yet they include in themselves enormous potential for unfolding a more richly differentiated understanding of self and world. Therefore early formulations, like the amoeba, can be unfolded and differentiated into much more complex and sophisticated "forms" of living. They need not be "fixed," replaced, or overthrown. In fact, the process of "working through" is precisely the unfolding of implicit positive perspectives and usages embedded in even the most negative of experiences.

The unfolding process is inherently interactional, and takes place in reference to a life context. Different potentials will be discovered and evolved depending on the particular life contexts the person encounters. We have seen already that Gendlin calls this "crossing." This unfolding can occur in either a positive or negative direction. It is the goal of therapy to bring out implicit positive potential, and further, to help individuals learn how to continue to self–evolve in a positive fashion (Bohart, 1991). "Crossing" the individual's prior ways of being with a new, positive supportive interactional context with a therapist, provides the opportunity for the client to evolve his personal meaning structures in more productive and proactive ways. Included in this evolution will be the accessing of emotion and its further carrying forward and integration.

Unfoldings then are discoveries of new meaning, or new implications concealed in, or implicit in old frameworks. As such they are a "carrying forward" (Gendlin, 1968) of old constructs and ideas. The old constructs are not lost so much as new aspects of their meaning is discovered: certain directions or implications in them are differentiated, elaborated, spelled out, and carried forward. Each carrying forward will itself contain implicit new directions for further development.

Implications for therapy. From a client–centered perspective the goal of therapy is to help the

self "become who one is." This sounds paradoxical: isn't everyone already the self who they are? If we view therapy traditionally, then we might assume, along the lines of object relations theory, that there is a "false self" overlaid on a "true self." The goal of therapy is to somehow free the true self from the false self. One then changes in therapy from "not being oneself" to "being oneself." However this concept has always bothered me. I always felt, even when I was struggling with my own problems in therapy in my 20's, that I was "myself," though certainly a more limited self than I wanted to be. Further, as a therapist, I have found that it is therapeutic to treat my clients as if they already were "themselves." I do not assume there is a "real self" somewhere down there, and that I am relating to a false self on the surface confronting me. I assume I am already relating to that whole person who is a real self.

But if this is so, then in what sense is it meaningful to describe therapy as a process of "becoming oneself?" I think precisely in the sense of therapy as an unfolding. What one is really doing is helping the client unfold the potential richness implicit in who the client already is. This potential richness may be being blocked by the client's defenses, lack of self acceptance, or inability to listen and trust his or her own process. The client may be unfolding and actualizing some aspects of his or her self (perhaps needs for security), while other very important aspects may lie untouched and unevolved (perhaps needs for meaning). This means that the client's "self" at the moment is limited compared to what it could be. It does not mean that it is false in comparison to what it could be. Therapy is expanding, enriching, unfolding, and bringing forth of implicit potential, rather than correcting, fixing, or freeing "true selves." Further, because there is always more implicit potential, one is always "limited" at any given moment in comparison to what one might become the next moment, and that is true of all of us. Therapy could be described as the process of becoming better and better at being who you are.

In this sense client–centered therapy can be seen as a "depth psychotherapy." If depth is the differentiation and articulation of implicit meanings, then client–centered therapy is as "deep" as psychoanalysis, in that it helps clients unfold and differentiate the rich implicit meanings in their prior organizations of experience.

In sum, personal knowing always includes implications for further evolution. One need not change people into other than they are. One need not alter core schemas or personality traits. One need merely help clients tap into the implicit potential in what they already know, how they already are, and help them become "more themselves."

Self Healing

There may be many different ways of self–healing. And "self–healing" is not necessarily a very good metaphor. In contrast to a person with the flu who can take to their bed and self–heal, psychological self–healing seems to be interactive. One does not merely "self–heal" by sitting there. At the very least one must be focusing (Gendlin, 1981) or meditating. More typically one "self–heals" by a) talking to someone else, b) reading a book (not necessarily a self–help book), c) painting a picture, d) gardening, e) volunteering to help others, f) creating a new organization (such as Mothers Against Drunk Driving), or g) seeing a therapist. In other words, there are many different ways to interact with the world in a way that will "carry forward" one's experience productively. In sum, "self"–healing needs to be understood as <u>self</u>–healing only in contrast to the idea that healing is something done to the self by an external agent (the therapist). Other than

that, it is not really "self" healing purely. It is interactive.

Further, therapist–assisted self–healing, as in cognitive and behavior therapy, may be different than self–propelled self–healing. With this proviso in mind, I will consider self–healing as it occurs in therapies that provide minimal prosthetic assistance. There are three: client–centered therapy, Gendlin's (1996) focusing–oriented therapy, and EMDR (Shapiro, 1995). In each of these a) the therapist does not give external feedback to "correct" the client's problem, and b) the process is rather one of supporting and facilitating the client's own stepwise emerging process. In client–centered therapy the therapist helps primarily through empathic listening and responding. Such responses are not meant to "give input" to the client. Nor are they meant to "make anything happen" in the client either. The process is one of the therapist testing his or her understanding of what the client is communicating on a moment to moment basis, but it is the client who takes the steps towards self–healing. What one can observe is a self–exploration process that can move from one step to the next, just like someone crossing a pond on stepping stones. The stones may not be arranged in a perfectly linear or logical fashion, but by going from one stone to the next the client eventually gets there.

Gendlin's focusing procedure is therapist–guided, but asks the client to generate the steps by focusing on the body, articulating or symbolizing what comes up, refocusing on the body, further articulating and symbolizing, and so on. An example from Leijssen (1998) is of a depressed woman who has been depressed since the birth of her child three years previously. The therapist asks her to direct her attention to the center of her body and to stay with the question "what is really the matter with me?" She begins to cry, and as she waits with that an image of her daughter being carried away from her immediately after birth occurs to her. As she follows this image and the tension in her body she has a further image of herself standing behind a window with her baby in the distance in an incubator. She despairs of ever reaching the baby. Anger at the gynecologist emerges, along with a feeling of pain. As she stays with these feelings and images she gradually comes to let go of this feeling she had carried with her for three years. The same process of stepping stones occurs here. The client goes from one step to the other, until resolution is reached.

EMDR (Shapiro, 1995) is a third therapeutic procedure which includes only minimal therapist input. The client is asked to focus on a troubling scene, and then to follow the therapist's fingers (or other forms of bilateral stimulation such as tapping the client's two hands). After a set of eye movements, the client is asked "what comes up." The client is then instructed to "go with that," i.e. focus on that, and then follow the therapist's fingers again. What happens with clients is again a kind of stepping–stone process where the initial scene transmorphs through various steps and stages into resolution. The steps and stages vary from client to client, and problem to problem. There does not appear to be any invariant order, as is also true in client–centered therapy and in focusing. Clients may (and frequently do) access deep emotion, but they may not. They may (and frequently do) access earlier memories, but they may not. The scene may change in various ways—sharpening, dimming, or the client may find him or herself focusing on different aspects. New thoughts and images may emerge. Emotions may emerge and shift.

So what is the process that seems to occur in these three approaches? I and two graduate students (Amy Corrigan and Michelle Bollman) have studied transcripts of EMDR (Shapiro & Forrest, 1997) and client–centered therapy (Rogers and Dymond, 1954). What I offer here are provisional comments on the nature of the self–healing process and what seems to make it occur.

The method we have used is the following. First, Amy and Michelle went through the transcripts and summarized as best they could in a stepwise fashion what had occurred. Then I went over these summaries and tried to see if I could understand the transitions. In so doing, I was functioning like an interpreter of literature, using a hermeneutical method. I went in with the bias of seeing if an implicational framework could be applied, that is, if implications could be seen in going from one step to the next.

My first observation is that these transcripts show a kind of orderly narrative flow that makes sense, although this is not a rational, logical deductive flow. The connections between any two steps cannot be deduced in advance in a logical fashion from the first step, as Gendlin (1990) has observed. One cannot look at what the client is thinking about/focusing on/experiencing in moment A, and predict the next step at moment B. Implication here is not logical deduction. Thus, in studying these transcripts, I was not expecting to come up with some kind of algorhythm which would allow prediction of one step from the previous one.

Instead I wanted to test Gendlin's contention that the steps make sense in retrospect. The issue was: are there plausible connections between the steps? Do they make sense? At least to me, the steps make sense in retrospect. In this regard, people who watch films of EMDR, client–centered therapy, or focusing, have no trouble following the client's development. Even when the shifts are new and unexpected, they make implicit sense to the audience. They can be surprising in a delightful unexpected plot twist kind of way, but they are not surprising in that they make sense in terms of what has come before. In fact, they "feel" surprisingly right, even when they do not logically follow. Gendlin implies that we can sense implicit connections in another's experience, which may be why these transitions can feel right even though they are not always easily explained in words. In using the hermeneutical method, I relied extensively on my own implicit sense of connections between two steps, and tried to explicate those in words.

What is clear to me from perusing the case examples we have studied is that while a) the steps of self healing have an implicit logic to them, (b) there is not a strictly constant sequence of content or emotion, c) the logic is not predictable in advance, d) the steps are based on adopting an exploratory versus a logical deductive attitude, e) the steps occur if the person is able to adopt a state of receptive, immediate, listening in which cognitive operations of analysis and deduction and trying to figure out are suspended or minimized, and f) the mental state is one of open, receptive attention instead of highly concentrated, focusing "trying" and "figuring out." This is not to say that the person does not think, but it is almost as if the thinking happens to the person, or occurs to them. Thoughts bubble up rather than being cognitively constructed. In fact, the state is one of emergence and discovery and recognition, rather than intellectual thinking. People

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This is not to say that the next step is not determined. It is however to say that for any given individual there are so many implicit possible directions based on that person's life time of experience and the complexity of his or her life situation that practically it will be impossible to predict the next step, even if it is determined.

report things "just occurring to them," just suddenly seeing things, and so on, rather than having to deliberately "think" them. This does not mean they are not deliberately thinking. In client-centered therapy there may be a struggle to articulate in words, but even there the best moments are when there is a kind of "bubbling up" into expression of experiences, emotions, and thoughts. Most of us know this process when it happens; at the very least we've experienced it in extremely good conversations with a "soul mate."

Below I give two cases in brief. One is a case from EMDR which illustrates the implicational nature of change. I will give the steps first, and then I will give each step and an analysis. The second case is a failure case from client–centered therapy, and although I will not give the content, I will give a brief summary of why it probably did not work.

The first case is from EMDR (Shapiro and Forrest, 1997). Emily comes to therapy because she is having trouble conceiving. While she was sexually abused as a child, what is bothering her now is that a psychiatrist has told her that since she was abused as a child she will abuse her own children if she has any.While she does not believe this in her head, she cannot rid herself of it at another level. During EMDR Emily is asked to focus on each scene or emotion that comes up. "EM" stands for each set of eye movements in the description to follow. First Emily relives the moment when hospital psychiatrist tells her she would molest her own children (EM). She gets sick (EM). This shifts to intense fear (EM) and then to total loss of hope. Then (EM) Emily shifts to a flood of anger and sees the psychiatrist as having abused her. Then (EM) she feels guilty that she had believed the psychiatrist. Then (EM) her emotions subside and she realizes she would never sexually abuse a child. A few weeks later she conceives.

There is an implicit logic in the order of steps that unfolds as Emily moves to resolution, although it is not predictable in advance. First Emily feels sick as she thinks of the psychiatrist telling her she will abuse her own child. This somewhat amorphous feeling has implicit in it the more specific and differentiated feeling of fear, which emerges in the next step. Emily is feeling sick because she fears she will abuse her child. Implicit in this fear is the implication that therefore it is hopeless, and that is the next emotion that emerges. When she experiences the total loss of hope, then, in a dialectical fashion, the opposite emerges. As she really totally feelingfully entertains the total loss of hope, suddenly a subdominant emotion of anger emerges. She is angry at the psychiatrist. And with the emergence of that anger comes a sense of positive self-affirmation, and implicitly a realization that she could not abuse a child and that she does not have to believe the psychiatrist. However she must go through one more logical step, which is to feel guilty ---why did she ever believe her in the first place? This step is a step of really fully accepting that she does not believe the psychiatrist, and accepting responsibility for herself. With the emergence of this step the next step, full realization that she will not abuse her child---she is too responsible, finally emerges, and she is subsequently able to conceive.

So why was she unable to go through these steps herself? What was keeping her stuck? We can use our imagination to intuit that at some level she stayed stuck because of fear. She feared the psychiatrist was right, and she could not let go of this fear just because intellectually she could contradict it. At some level, her body was saying to her: "What if the psychiatrist is right?" This implicit question was keeping her stuck, while at a conscious level she was busy telling herself this was illogical. Her paralysis came out of two sources. First it came out of her moral sense. She couldn't let it go until she was sure she wouldn't abuse her child. She had to really get that at a gut level before she was willing to let it go. Second, her paralysis came out of her

attempts to logically analyze her problem intellectually, rather than pay attention to her body and see what emerges. In the EMDR she did not engage in this kind of analysis. Instead, she listened to her body, accessed the implicit fear and hopelessness, then recognized that her psychiatrist had abused her and felt angry, stayed with that anger and did not intellectualize, and then recognized her own moral sense and that she would not abuse a child. This all happened by not-thinking in some highly analytic cognitive sense, but rather by listening, attending, and recognizing what came up.

In contrast, in a failure case from Carl Rogers (Rogers & Dymond, 1954), the client rarely stops and listens to the bodily felt sense. Instead he typically does two things: first, when he thinks one thing, he logically deduces from it what it must mean, and goes to another logical deduction. Second, when he does attend to his body and his emotions he does the same thing-- he relates to his feelings in an observational, logically analytic way, and deduces that because he is feeling such and such, it must mean X and Y. He is reporting on himself, and analyzing himself, and "self-engineering" rather than receptively attending to what comes up. Examples include the following:

"I've somewhat questioned my necessity for seeking counseling help. Because it seem to be a reasonable inference that the solution to any problem that you might find more or less it lies within the individual, I mean it seems that to me that he should be capable of reasoning and reflecting about them himself...and...its just a little...ridiculous. I mean, seeking out [help]...seems to me it's sort of a manifestation of my own inferiority in trying to solve my own problems." (p. 361, quotation shorted and condensed).

"Maybe the fact that it appears to me that I'm not getting anywhere might be indicative of the fact that what I find within myself is not in concord with my intuitive knowledge of what I hope to find..." (p. 362, quotation shortened and condensed).

Theoretical Integration

I conclude with a model of how self–healing works. The question to ask is, if we can self–heal, why then do we get stuck? The first answer is that the implicit complexity of the problem exceeds the forms/ideas/concepts we have to solve the problem. The second answer is that we try to think with old forms rather than engage in the back and forth listening to experience process that creates new movements. In other words, we function in too "top down" a way. The insight that it is the way we think about problems that in some way causes them or freezes them is one of the most universal insights of psychotherapy. It has been held in various forms by Watzlawick, Freud, Mahrer, Erickson, Rogers, and even cognitive therapists such as Beck and Ellis. We have already seen how Rogers' failure case was functioning in an almost strictly top down fashion. He was particularly good at deciding what he should be doing and then telling himself what he should be doing. I do not see such top down processing as a) necessarily creating personal problems, as Rogers and others did, nor b) do I see it as always dysfunctional. Sometimes one can analyze a situation, identify a putative cause, and take productive action. Rather, I believe that such processing is not useful when any complexity is involved, and new carrying forward is needed. It is not that such activity creates the problem; however it is such activity which seems to block the processes involved in productive living through and carrying forward.

My basic hypothesis is that it is this kind of top down activity which often interferes with self–healing and freezes traumatic experience into place. In other words, much like Watzlawick

et al. (1974) say, it is our attempts at solution which cause problems. Often this activity itself is implicit. In particular it is the person's worries and fears that they did something wrong that often interfere with their attempts at self–healing. In the case of Emily the problem is that, although Emily does not believe in her head what the psychiatrist has told her, that she would abuse her child because she was abused, she cannot get it out of her head. She continues to at least worry about it, even if she does not completely or necessarily believe it. Other cases in Shapiro and Forrest also involve overcoming implicit or explicit self-criticism or self-doubt before self-healing can take place.

In sum, it appears that it is a cognitive topdown concern that "my problem is my fault" which seems to be a component in blocking the self–healing process and keeping people stuck (see also Wile, 1981, for a view which emphasizes self-criticism as blocking more productive attempts to cope). Yet this can be seen as an implicit move to self–healing which paradoxically keeps the client stuck. This is an implicit move to self–healing because it is almost as if it is the client's attempts to be <u>honest</u> with him or herself which keeps him or her stuck. He or she does not want to let go of the problem until he or she is sure he or she is not overlooking his or her role in it. Hanging on to the trauma seems to come out of the implicit desire for self–healing. Thus it is the activities of self–doubt, self–criticism, or potential self–criticism which freeze the person. It is the lack of certainty. And the person will not be convinced by just words. The person needs to be convinced experientially.

Following on this, the healing process seems to work by interrupting the implicit or explicit self doubt or self criticism. The person is asked to think of the scene and focus on the moving fingers. What this seems to do is to interrupt the kind of cognitive thinking, analysis, and so on, which seems to disrupt the natural emergence of the implicit steps for growth. The person focuses on his or her experience, and then waits to see what emerges. What emerges is a sequence of feelings, shifts in scenes, focusing in scenes, new creative images, and so on, all because the person suspends attempts at cognitive, left brain kinds of analyses. The person is able to engage in the natural stepwise process. In addition the client seems to be in a state of mind where he or she is free to actually experience. Things bubble up. Ideas and images come to mind in the same natural spontaneous way when people are really in a highly focused state of mind. What emerges brings things into balance. People are able to let go, forive themselves, accept the parts they may have been responsible for, and look towards the future.

If we are able to "stay with" experience in just the right way, an implicit order of steps emerges (Gendlin, 1990). We can often sense that we know this, but cannot put it into words, or get a handle on it. And then, because we are desperate, we jump to "what it must be." This makes internal listening the key to a self–propelled moving–forward process. This internal listening is not just a passive listening, it is a back and forth of listening, testing, formulating checking, listening and so on. It is a devoting of careful receptive attention. But it is going with the pace of the body.

In particular, the process seems to work through a) acceptance of inner experience, and b) a kind of receptive listening attention to inner experience. This is common to Gendlin's focusing therapy, client-centered therapy, EMDR, and to Mahrer's experiential therapy when used as a self-help technique. In other words, inner wisdom seems to be freed up when clients attend to themselves in this particular way, rather than engage in highly cognitive, analytic, problem-solving activities. Recently, Kirsch and Lynn (1999) have reviewed research

suggesting that much of behavior is "involuntary," by which they mean it is not caused by cognitive, top down activity. Instead, cognitive top down activity works primarily by devoting attention to different schemas, which differentially primes and activates them. I do not entirely embrace Kirsch and Lynn's information-processing view, which sounds a bit mechanistic to me, but they are making essentially the same point--that it is attention which creates activation and inner movement..

In sum, self-healing seems to occur when the client allows and accepts inner experience, suspends highly cognitively analytic top down processing, suspends self-criticism or works through self-criticism, and begins to receptively listen to both thoughts and experience. When this occurs, a natural self-wise self-healing process, implicational in nature, emerges.

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